Summary of Benefits

ALERT! Even if a provider orders a test or prescribes a treatment, the plan may not cover it. Please review this *Certificate of Coverage* or call Customer Service at 1-888-849-3681 if you have questions about benefits or limitations.

On the next several pages, you'll find a summary of your plan benefits, a convenient reference to help you find the information you need. For a complete understanding of how a benefit works, it is important that you also read the pages listed in the "For More Information" column.

Not all benefits are listed. For services not listed, see the Table of Contents or call UMP Customer Service at 1-888-849-3681.

In order to be covered, all services must be medically necessary (see the definition on pages 192–194).

If you see an unfamiliar term, see the alphabetical list of definitions on pages 181–206.

This Certificate of Coverage applies ***only*** *to dates of service between the day your coverage begins (but no earlier than January 1,* 2016*) and the day your coverage ends (no later than December 31,* 2016*).*

ALERT! If a dependent has coverage under another health plan, see pages 112–121.

Deductibles and Limits

What is it?	How much is it?	What else do I need to know?	For more information: See page(s)
Deductible	▪ $1,400 for one person on the account ▪ $2,800 for two or more persons on an account (family) ▪ If you qualified for the 2016 SmartHealth wellness incentive, PEBB will deposit $125 into your Health Savings Account.	▪ This deductible applies to all services, including prescription drugs, unless specifically stated the services are not subject to the deductible. ▪ For a family account, you must meet the entire $2,800 deductible. ▪ You pay toward this deductible before the plan pays for covered services. ▪ You don't have to pay the deductible for some services. ▪ Not all services count toward this deductible.	20–22
Out-of-pocket limit	▪ $4,200 for one person on the account ▪ $8,400 for two or more persons on an account (family)	▪ Your deductible and prescription drug costs count toward this limit. ▪ Not all services count toward this limit. ▪ No individual within a family can exceed $6,850 of covered out-of-pocket expenses.	23–25
Health Savings Account (HSA) *If the subscriber is age 55 or older, may contribute up to an additional $1,000.*	▪ Maximum annual contribution: ▪ Account with one person $3,350 ▪ Account with two or more persons: $6,750	▪ You may pay for any qualified medical expenses (see definition on page 202) from your HSA, including: ▪ Services that apply to your deductible. ▪ Services that are not covered by the plan, but are still qualified medical expenses	25

What is it?	How much is it?	What else do I need to know?	For more information: See page(s)
Annual plan payment limit	None	No limit to how much the plan pays per calendar year.	Not applicable
Lifetime plan payment limit	None	No limit to how much the plan pays over a lifetime.	Not applicable

How Much Will I Pay?

The table below describes how much you'll pay for services. Unless otherwise noted, all payment is based on the allowed amount, which is the fee accepted as payment by a preferred provider, and services are subject to the deductible. See the Summary of Benefits table on pages 31–40 for which type of service applies to a specific benefit.

Type of Service	How Much You Pay
Standard Subject to the deductible; see pages 20–22.	How much you pay (your coinsurance) depends on the provider's network status: ▪ **Preferred providers**—You pay 15% of the allowed amount. ▪ **Out-of-network providers**—You pay 40% of the allowed amount; the provider may balance bill (see page 183). ▪ **Participating providers**—You pay 40% of the allowed amount; the provider may not balance bill. Indicated by $$ in the provider directory on **regence.com**.
Preventive Preventive services are not subject to the deductible (you don't have to pay your deductible before the plan pays).	How much you pay (your coinsurance) depends on the provider's network status: ▪ **Preferred and participating providers**—You pay $0: the plan pays in full. ▪ **Out-of-network providers**—You pay 40%; the provider may balance bill.

Type of Service	How Much You Pay
Inpatient Subject to the deductible; see pages 20–22. ▪ Facility charges and professional services (such as physicians and lab tests) are usually billed separately. See a specific benefit—for example, diagnostic tests—for how these related services are covered. ▪ Professional providers may contract separately from a facility. Even if a facility is preferred, a professional provider may not be. ▪ Most inpatient services require both: ♦ **Preauthorization:** See page 100 for a description of how this works. ♦ **Notification:** Your provider must notify the plan upon admission to a facility; see page 101 for a description of how this works.	How much you pay (your coinsurance) depends on the provider's* network status: ▪ **Preferred providers**—You pay 15% of the allowed amount. ▪ **Out-of-network providers**—You pay 40% of the allowed amount; the provider may balance bill (see page 18). ▪ **Participating providers**—You pay 40% of the allowed amount; the provider may not balance bill. Indicated by $$ in the provider directory on **regence.com**. Services are considered inpatient only when you are admitted as an inpatient to a facility. See definition of "Inpatient Stay" on page 190. **A facility, such as a hospital, may be referred to as a "provider."*
Special Subject to the deductible; see page 20.	These services have unique payment rules, which are described in the "How much will I pay?" column on pages 31–40.

What else do I need to know?

- Some services aren't covered; see pages 105–111 for some of the services not covered by the plan.
- You don't need a referral from the plan to see a specialist for most services. However, you will save money by seeing preferred providers, especially for preventive services; see page 13.
- Preexisting conditions: There is no waiting period; medically necessary covered services are eligible for benefits from the effective date of your medical enrollment.

Summary of Benefits

Only certain services are listed in the table. For those not listed, see the alphabetical list of covered benefits on pages 41–81 or call Customer Service at 1-888-849-3681.

Please read the pages listed in the "For more information" column for each benefit. Not all details are included in the table. We recommend that you also review:

- Services that require preauthorization (see page 100 for how this works); see page 101 for how to find the current list at **www.hca.wa.gov/ump** or call 1-888-849-3681.
- Services for which your provider must notify the plan; see current list at **www.hca.wa.gov/ump** or call 1-888-849-3681.
- Services that aren't covered (exclusions; see pages 105–111).

If you have questions about services that require preauthorization or plan notification, or services not covered by the plan, call Customer Service at 1-888-849-3681.

Benefit/Service	How much will I pay? (See pages 29–30 for description of payment types)	For more information: See page(s)	Any limitations or exclusions?
Ambulance	**Special:** 20% of the allowed amount for preferred or out-of-network providers. Out-of-network providers may balance bill.	43, 105, 110	Covered only for a medical emergency (see definition on page 191).
Applied Behavior Analysis (ABA) Therapy	Standard	44	Specific preauthorization requirements; see page 44. Only specified providers are covered; see page 44.

For services requiring preauthorization or plan notification:* *See the list of services at* **www.hca.wa.gov/ump, *or call 1-888-849-3681. Many services require* ***both*** *preauthorization and plan notification. See* pages 100–102 *for how this works.*

Benefit/Service	How much will I pay? (See pages 29–30 for description of payment types)	For more information: See page(s)	Any limitations or exclusions?
Chemical Dependency Treatment			
Inpatient Services	Inpatient	46, 109	See page 46 for preauthorization of inpatient services. Plan notification is required at the time of admission.*
Outpatient Services	Standard	46, 109	See page 46 for services that may require preauthorization.* May be subject to review for medical necessity.
Chiropractic Physician Services		75	See "Spinal and Extremity Manipulations" on page 38.
Contraceptive Services for Women	Preventive or Standard	56–58, 72	See page 57 for services that are covered as preventive. Some contraceptive services may be covered as Standard.
Dental Services	**Special:** You pay 20% of the allowed amount. No preferred dentists; providers may balance bill (see definition on page 183)	48, 106	See "Dental Services" on page 48 for limitations on covered services.

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Benefit/Service	How much will I pay? (See pages 29–30 for description of payment types)	For more information: See page(s)	Any limitations or exclusions?
Diabetes Care Supplies	**Special:** Paid under the prescription drug benefit; see pages at right.	50, 118	See "How Are Diabetes Care Supplies Covered When UMP CDHP Pays Second?" on page 118 if another plan pays first.
Diabetes Control Program: NOT ME	Preventive	51	Only the NOT ME program is covered.
Diabetes Prevention Program: NOT ME	Preventive	51	Only the NOT ME program is covered.
Diagnostic Tests, Laboratory, and X-Rays	Standard	52, 69, 105, 108, 110	Usually billed separately from related office visits or inpatient services.
Durable Medical Equipment, Supplies, and Prostheses	Standard	53–55, 80, 86, 106, 109, 185	May require preauthorization.* Some breast pumps are covered as preventive; see "Services Covered as Preventive" on page 68.
Emergency Room (ER)	Standard	56, 191	Services determined not to be due to a medical emergency (page 191) are not covered in an emergency room setting.

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Benefit/Service	How much will I pay? (See pages 29–30 for description of payment types)	For more information: See page(s)	Any limitations or exclusions?
End-of-Life Counseling	▪ If received as part of hospice: Paid at 100% after meeting your deductible. ▪ If received outside of hospice services: Standard.	56	Total of 30 visits, all services combined.
Family Planning Services	Standard *Some contraceptive services are covered as preventive; see page 57.*	56–58, 107	Not covered: ▪ Infertility services ▪ Reversal of sterilization
Hearing Aids	**Special:** Plan pays up to $800.	59	Limited to $800 plan payment per three calendar years.
Hearing Exams, Routine	Standard	59, 72	Newborn hearing screening is covered as preventive.
Home Health Care	Standard	61, 76, 107, 184, 189, 191	See page 61 for what is covered. Specific services are not covered; see exclusion 24 on page 107. Maintenance care (page 191) and custodial care (page 184) are not covered.

*****For services requiring preauthorization or plan notification:*** *See the list of services at* **www.hca.wa.gov/ump***, or call 1-888-849-3681. Many services require* ***both*** *preauthorization and plan notification. See* pages 100–102 *for how this works.*

Benefit/Service	How much will I pay? (See pages 29–30 for description of payment types)	For more information: See page(s)	Any limitations or exclusions?
Hospice Care (Includes respite care)	**Special:** Paid at 100% after meeting deductible.	61, 189, 204	Covered for terminally ill members for up to six months. Respite care is limited to 14 visits per lifetime.
Hospital Services			
Inpatient Services	Inpatient	62, 67–70, 107	All elective inpatient admissions (except maternity) require preauthorization.* Plan notification is required for all hospital admissions within 24 hours of admission.* Inpatient rehabilitation services require preauthorization.*
Outpatient Services	Standard	62	Some services require preauthorization.*
Immunizations (Vaccines)	Preventive (usually)	73, 107, 194	Covered under CDC recommendations; see page 73. Not covered for travel or employment.

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Benefit/Service	How much will I pay? (See pages 29–30 for description of payment types)	For more information: See page(s)	Any limitations or exclusions?
Mammograms (Diagnostic)	Standard	64	Must be billed as diagnostic by the provider.
Mammograms (Screening) *See "Breast Health Screening Tests" on page 45 for additional services covered.*	Preventive	45, 64	**Women age 40 and older:** Covered every one to two years. **Women under age 40:** Covered as preventive only for women at increased risk; see page 64 for details. For women under age 40 and not at increased risk, see page 64. *See "Breast Health Screening Tests" on page 45 for additional services covered.*
Massage Therapy	Standard	65, 108	Limited to 16 visits per calendar year. Only preferred massage therapists are covered.
Mastectomy and Breast Reconstruction	Standard	53, 65	All inpatient services require plan notification.*

****For services requiring preauthorization or plan notification:** See the list of services at **www.hca.wa.gov/ump**, or call 1-888-849-3681. Many services require **both** preauthorization and plan notification. See pages 100–102 for how this works.*

Benefit/Service	How much will I pay? (See pages 29–30 for description of payment types)	For more information: See page(s)	Any limitations or exclusions?
Mental Health Treatment			
Inpatient Services	Inpatient	66, 109	See page 66 about preauthorization of inpatient services. Plan notification is required at the time of admission.*
Outpatient Services	Standard	66, 108, 109	See page 66 for services that require plan notification.*
Naturopathic Physician Services	Standard	17, 66, 97, 106	Herbs, vitamins, and other supplements are not covered. See "Exceptions Covered" on page 94 for exceptions.
Obstetric and Newborn Care	Inpatient (Standard for related outpatient visits) *Some breast pumps are covered as preventive; see* page 68.	67–70, 110	For non-routine services for a newborn, you may pay an additional deductible or separate coinsurance; see page 69. See page 68 for coverage of circumcision for males, which is not a preventive service.
Office Visits	Standard	70, 108	See pages 72–74 for routine exams covered as preventive.

For services requiring preauthorization or plan notification:* *See the list of services at* **www.hca.wa.gov/ump, *or call 1-888-849-3681. Many services require* ***both*** *preauthorization and plan notification. See* pages 100–102 *for how this works.*

Benefit/Service	How much will I pay? (See pages 29–30 for description of payment types)	For more information: See page(s)	Any limitations or exclusions?
Physical, Occupational, Speech, and Neurodevelopmental Therapy	Standard Inpatient services are usually charged separately from facility charges.	71, 108, 191	**Inpatient:** 60 days maximum per calendar year. **Outpatient:** 60 visits maximum per calendar year.
Prescription Drugs	15% after deductible is met.	82–99	See exclusions on pages 105–111, and other limits on pages 88–91.
Preventive Care Includes vaccines, routine exams, some screening tests	Preventive	64, 68, 72–74, 96, 200	Only certain services are covered as preventive; see pages 72–74. See page 68 for contraception covered as preventive.
Skilled Nursing Facility	Inpatient *Some services may be billed separately (such as physical therapy).*	74, 108, 110, 204	Maintenance care (page 191) and custodial care (page 184) are not covered.
Spinal and Extremity Manipulations	Standard	75, 108	Limited to 10 visits per calendar year.

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Benefit/Service	How much will I pay? (See pages 29–30 for description of payment types)	For more information: See page(s)	Any limitations or exclusions?
Surgery		49, 62, 65, 70, 75, 79, 107, 110, 182, 196, 202	Bariatric surgery: page 45. Transgender surgery: page 79.
Inpatient Services	Inpatient		Some services require preauthorization and/or plan notification.*
Outpatient Services	Standard		Some services require preauthorization.*
Telemedicine Services	Standard	76	
Tobacco Cessation Services	Preventive	77	See page 77 for coverage of drugs and nicotine replacement supplies. See page 78 for tobacco cessation services for members ages 17 and under.
Transgender Services	Standard	79	Some services require preauthorization and/or plan notification. See page 79 for covered services.
Urgent Care	Standard	80	
Vision Care (Related to Diseases and Disorders of the Eye)	Standard	80, 105, 107, 108	

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Benefit/Service	How much will I pay? (See pages 29–30 for description of payment types)	For more information: See page(s)	Any limitations or exclusions?
Vision Exams, Routine	Preventive	80, 107, 108	One per calendar year. The plan pays up to $65 per year for contact lens fitting fees; you pay any additional charges.
Vision Hardware, Adults (Over age 18) Glasses, contact lenses	**Special:** You pay any amount over $150; network status of provider does not matter. No deductible.	81	Plan pays up to $150 per two calendar years (resets every even year).
Vision Hardware, Children (Age 18 and under) Glasses, contact lenses	**Special:** No deductible. **Eyeglasses:** You pay $0 for one set of standard or deluxe frames and lenses per year. **Contact lenses:** You pay 15% of billed charges.	72–74	Plan pays for one pair of eyeglasses per year at 100% of billed charges. See page 81 for options that aren't covered. No limit on number of contact lenses covered.
Well-Child Visits	Preventive	72–74	See pages 72–74.

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